

**MARY ENGLUND, PSYD, LLC  
PATIENT REGISTRATION FORM- **MINOR****

(Please Print)				
Today's Date:	Appt. With:	Whom may we thank for referring you?		
<b>PATIENT INFORMATION</b>				
Last Name, First Name, Middle Initial			Birth Date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address	City	State	Zip Code	Home Phone No.:
<b>PHONE NO. WE MAY LEAVE A MESSAGE ABOUT PATIENT?</b>				
<b>MOTHER'S INFORMATION</b>				
Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code	Cell Phone No.:
Employer's Name, Address and Work Phone				
<b>FATHER'S INFORMATION</b>				
Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code	Cell Phone No.:
Employer's Name, Address, and Work Phone				
<b>PRIMARY INSURANCE INFORMATION</b>				
Insured's Last Name, First Name, Middle Initial			Birth Date:	Social Security #
Insurance Company			Phone Number	
Insurance Billing Address:				
Policy No.:	Group no.:	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
<b>SECONDARY INSURANCE INFORMATION (IF APPLICABLE)</b>				
Insured's Last Name, First Name, Middle Initial			Birth Date:	Social Security #
Insurance Company			Phone Number	
Insurance Billing Address:				
Policy No.:	Group no.:	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Mary Englund, PsyD LLC and those acting on the practice's behalf and the insurance company to release any information required to process my claims. Furthermore, I have reviewed the Notice of Privacy Practices & the Professional Service Agreement provided. I fully understand and accept the terms of this practice.				
Signature of Patient (age 12 & older)			Date	
Guardian Signature			Date	

